

Maternity Care and Delivery

- A prenatal assessment (state-unique code 5930M) can be billed in addition to antepartum care. Only one prenatal assessment will be reimbursed per billing provider, per client, per pregnancy. MAA recommends that the Washington State Physicians Insurance Association (WSPIA) assessment form be used as a guide for your assessment.
- **Total obstetrical care (CPT code 59400) includes:**
 - ✓ Routine antepartum care in any trimester;
 - ✓ Delivery; and
 - ✓ Postpartum care.
- Bill a global obstetric procedure code after you have performed **all** of the services.
- Providers may also bill these routine antepartum services separately using the following state-unique codes and the appropriate CPT delivery only or delivery/postpartum only code:

State-Unique Code	Description	Limitations
5951M	Routine antepartum care, first and second trimester, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of six (6) total.
5952M	Routine antepartum care, third trimester, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.

- ✓ Routine antepartum care must be billed in sequential months.
- ✓ Use a separate line for each calendar month, indicating the date of service.
- ✓ Three separate months of antepartum care equal one full trimester of care.
- If you provide all or part of an MAA's client's antepartum and/or postpartum care, but do not perform the delivery, you must bill using the appropriate trimester or postpartum procedure codes. Bill **only** for the actual care you provided to a client.
- If you provide part of an MAA client's antepartum and postpartum care, and perform the delivery, you must bill only for the actual care you provided.
- **Antepartum care includes** prenatal services (initial and subsequent history, physical examination, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, maternity counseling).

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Physician-Related Services

- Necessary prenatal lab tests can be billed in addition to maternity services, **except urine dipstick tests (CPT codes 81000, 81001, 81002, 81003, and 81007).**
- Routine antepartum care procedure codes are not allowed in combination with any vaginal deliver or cesarean section procedure code that includes antepartum care.
- If a high-risk condition exists, bill the appropriate prenatal high-risk management code(s) in addition to routine antepartum care. When billing high-risk pregnancy codes, use an ICD-9-CM diagnosis code that reflects high-risk.

A high-risk condition exists when a pregnant client:


- ✓ Has a high-risk medical condition; and/or
- ✓ Has a diagnosis of multiple births.

The diagnosis on the detail line of the claim form must be the diagnosis that qualifies the pregnancy as high-risk.

- The following state-unique codes for the monthly high-risk add-on fees must be used according to the trimester of care:

State-Unique Code	Description	Limitations
5953M	High-risk management, first trimester, add-on, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.
5954M	High-risk management, second trimester, add-on per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.
5955M	High-risk management, third trimester, add-on, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.


- ✓ High-risk management must be billed in sequential months.
- ✓ Use a separate line for each calendar month, indicating the date of service.
- ✓ Three separate months of high-risk management equal one full trimester of care.

 **NOTE:** Additional services for antepartum care or high-risk management may be allowed in certain circumstances, such as when the client moves, transfers care to a new provider, etc. In order for MAA to consider payment, providers must indicate the reason for additional services in field 19 of the HCFA-1500 claim form or in the *Comments* field when billing electronically.

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Physician-Related Services

- Medical problems during prenatal/trimester or postpartum care may require additional services. Bill for treatment of these problems using the Evaluation and Management (E&M) Services codes. MAA will reimburse for the medical services in addition to obstetrical care. Bill using the appropriate medical diagnosis.
- Bill MAA for consultations using consultation CPT codes 99241-99255. If a follow-up consultation is necessary, bill using CPT codes 99261-99263.

 **Note:** Maternity Case Management services are available through certain providers to help pregnant women gain access to medical, social, educational and other services. The Maternity Support Services program also supports these women. This program provides preventive health services in the home or clinic for women throughout pregnancy and up to 60 days after delivery.

For information on maternity case management services and maternity support services, call **MAA's Family Services Section at (360) 725-1655.**

- When a high-risk delivery condition exists, the procedure code for high-risk vaginal delivery add-on (state-unique code 5941M) can be billed in addition to routine vaginal delivery. You must also use an appropriate corresponding ICD-9-CM diagnosis code.
- Bill labor management (state-unique code 5935M) for care provided by the physician who has managed prenatal care but does not perform the delivery due to unanticipated medical complications. The client must be in active labor and must be admitted to a hospital or certified birthing facility when the referral to the delivering physician is made.
- Do not bill CPT code 59430 (postpartum care only) in addition to procedure codes that include postpartum care.
- MAA reimburses a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for 2nd or 3rd baby, use delivery only codes. Delivery only codes are paid at 50% of that procedure code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form, "twins" or "triplets."
- OB/GYN consultants may bill external cephalic version (CPT code 59412) and a consultation when performed on the same date of service.
- To bill for anesthesia during delivery, see the Anesthesia Section.
- For deliveries in a Birthing Center, refer to MAA's [Births in Birthing Centers Billing Instructions](#). For deliveries in a home birth setting, refer to MAA's [Planned Home Births Billing Instructions](#).

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Cesarean Delivery

- MAA reimburses for multiple births at cesarean delivery at 100% for the first baby. No additional reimbursement will be made for additional babies.
- Bill labor management (state-unique code 5935M) for care provided by the physician who has managed prenatal care but does not perform the cesarean section. The client must be in active labor and admitted to a hospital or licensed birthing center when the referral to the delivering physician is made.
- You may bill state-unique code 5959M for high-risk cesarean delivery add-on in addition to a cesarean delivery when a high-risk delivery condition exists and the appropriate ICD-9-CM diagnosis is used. A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99440, when appropriate.
- If you have performed the antepartum and postpartum care and assisted at cesarean delivery, use state-unique code 5947M. Do not use modifier 80.
- Do not bill postpartum care only (CPT code 59430), in addition to procedure codes that include postpartum care.
- To bill for anesthesia during delivery, see the Anesthesia Section.
- Physician assistants must bill for an assist for a C Section delivery on the same claim form as the physician using modifiers 80, 81 or 82.
- RNFAs bill for cesarean sections using modifier 80.

Smoking Cessation For Pregnant Women

MAA reimburses providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit for tobacco dependent eligible pregnant women.

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent, pregnant women who are enrolled in a managed care plan must have services arranged and referred by their primary care provider (PCP). Clients covered under a managed care plan will have a plan indicator in the HMO column on their Medical Identification card. Do not bill MAA for Smoking Cessation Counseling as it is included in the managed care plans' reimbursement rates.

Who is eligible to be reimbursed for smoking cessation counseling?

MAA will reimburse only the following providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians;
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is Smoking Cessation Counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy, as needed (see next page); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

What is covered?

- MAA will allow one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on the following page.
- MAA covers two levels of counseling. Counseling levels are:
 - ✓ Basic counseling (approximately 15 minutes) which includes Steps 1-3 on previous page; and
 - ✓ Intensive counseling (approximately 30 minutes) which includes Steps 1-5 on previous page.
- Use the most appropriate procedure code from the following chart when billing for smoking cessation:

CPT Procedure Code	Brief Description	Restricted to Diagnoses:
99401	Preventive counseling, indiv [approximately 15 minutes]	648.43 (antepartum) 648.44 (postpartum)
99402	Preventive counseling, indiv [approximately 30 minutes]	648.43 (antepartum) 648.44 (postpartum)

- A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment is appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:
 - ✓ MAA covers Zyban[®] only;
 - ✓ The product must be prescribed by a physician, ARNP, or physician assistant;
 - ✓ The client for whom the product is prescribed must be 18 years of age or older;
 - ✓ The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and
 - ✓ The provider must include both of the following on the client's prescription:
 - The client's estimated or actual delivery date; and
 - Notation that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban[®], pharmacy providers must call:

Drug Utilization and Review
1-800-848-2842

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Insert copy of provider Smoking Cessation form here.

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Chemotherapy Services

[Refer to WAC 388-531-0950(11)]

When chemotherapy is administered in the physician's office, but there is no face-to-face contact with the physician, the E&M CPT code 99211 may be used to bill for this service if:

- The physician personally supervises the E/M services furnished by office medical staff; and
- The medical record reflects the physician's active participation in or management of course of treatment.

See the listing of J & Q injection drug codes in this document. Use the following procedures to bill for chemotherapy drugs (HCPCS codes J9000-J9999):

- The definition of the unit of service is based on the HCPCS descriptions;
- Maximum allowable is 95% of Medicare's rate.

This method of setting the maximum allowable payment rates is based on the current methodology used to set the payment rates for prescription drugs under MAA's Prescription Drug Program. MAA sets this level of payment to take into consideration the cost of the drug. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less. The same basis for payment (per unit) is used for both single- and multi-dose vials, but the unit allowance would vary by drug.

I. Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s) used including partial vials. The HCPCS descriptions for the J Codes (J9000 through J9999) establish the unit of service. Based on this unit definition, the maximum allowable per unit is MAA's maximum allowable price. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less.

Example:

If a total of 150 mg of Etoposide were required for the therapy, and two 100 mg single dose vials were required to obtain the total dosage, then the total of the two 100 mg vials would be billable. In this case, the procedure would be billed under J9181 (Etoposide, 10 mg), with the maximum allowable price at \$4.38 per 10 mg unit, the total allowable would be \$87.60 (200 mg divided by 10 = 20 units x \$4.38). This would then be compared to the billed amount.

II. Multi-Dose Vials:

For multi-dose vials, bill only the number of units (rounded to the nearest whole unit) of the drug used. The HCPCS descriptions for the J Codes (J9000 through J9999) establish the unit of service. Based on this unit definition, the maximum allowable per unit is MAA's maximum allowable price. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less.

Example:

If a total of 750 mg of Cytarabine were required for the therapy, and was taken from a 2,000 mg multi-dose vial, then only the 750 mg used would be billable. In this case, the procedure would be billed under J9110 (Cytarabine, 500 mg), with the maximum allowable price at \$23.75 per 500 mg unit, the total allowable would be \$47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x \$23.75].

III. Unlisted Drugs:

When there is no J Code available to define the drug used and unit of service, the provider determines the number of units used and bills total units. Claims must include the drug used, dosage, strength and the National Drug Code (NDC) in the *Comments* field. Claims will be denied if the information is not included on the claim. The NDC for the drug determines the total allowable by using MAA's pricing multiplied by the number of units billed. The same policies regarding the billing of single and multi-dose vials apply. MAA's payment is the billed amount or MAA's maximum allowable rates, whichever is less.

Oral Anti-Emetic Drugs

In order to bill MAA for HCPCS codes Q0163 through Q0181, the drug must be:

1. Part of a cancer chemotherapy regimen, administered or prescribed for use immediately before, during, or within 48 hours after the time of administration of the chemotherapeutic agent;
2. Covered by a valid diagnosis code. [Valid diagnosis codes are 140.0 through 239.9, (excluding 210.0 through 229.9) and V58.1]; and
3. Submitted on the same claim form with one of the anti-neoplastic (cancer) drug procedure codes J8530 through J9999.

Hydration Therapy and Chemotherapy

Intravenous (IV) infusion of saline, an anti-emetic, or any other nonchemotherapy drug (CPT codes 90780 and 90781) is not reimbursed separately when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate reimbursement will be allowed for IV infusion when administered on the same day but **before or after** rather than at the same time as the chemotherapy infusion. Use modifier 59 to indicate IV infusion was performed sequentially.

Surgical Services

[Refer to WAC 388-531-1700]

Global Surgery Policy – Global surgery reimbursement includes all the following services:

- The operation itself.
- Preoperative visits for major surgeries, in or out of the hospital, beginning on the *day before* surgery.
- Preoperative visits for minor surgeries beginning on the *day of* surgery.
- Services by the primary surgeon, in or out of the hospital during the postoperative period.
- Postoperative dressing changes, including:
 - ✓ Local incision care and removal of operative packs;
 - ✓ Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes;
 - ✓ Change and removal of tracheostomy tubes;
- All additional medical or surgical services required because of complications that do not require additional operating room procedures.



Note: Casting materials are not part of the global surgery policy and are paid separately

Global Surgery Reimbursement

1. The global surgery reimbursement period applies to any provider who participated in the surgical procedure. These providers include:
 - Surgeon
 - Assistant surgeon (modifiers 80, 81, or 82)
 - Two surgeons (modifier 62)
 - Team surgeons (modifier 66)
 - Anesthesiologists and CRNAs

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2. The following procedure codes are included in the global surgery reimbursement period unless E&M is billed with a modifier. (See modifiers below for E&M.)

E&M CPT Code

99211 through 99223
 99231 through 99239
 99241 through 99245
 99251 through 99255
 99261 through 99263
 99271 through 99275
 99291 through 99292
 99301 through 99303
 99311 through 99316
 99331 through 99333
 99347 through 99353
 99374 through 99375
 99377

Ophthalmological CPT Codes

92012 and 92014

<u>Modifier</u>	<u>Description</u>
24	Unrelated E&M service by the same physician during a postoperative period (reason for the E&M service must be unrelated to the procedure)
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure (reason for the E&M service must be unrelated to the procedure)
57	Decision for surgery (only applies to surgeries with a 90-day global period)
79	Unrelated procedure or service by the same physician during the postoperative period

Professional inpatient services (CPT codes 99221 through 99223) are payable only during the follow-up day period if they are performed on an emergency basis (i.e., they are not payable for schedule hospital admissions).

Procedure codes that are considered *bundled* are **not payable** during the global surgery reimbursement period.

A physician other than the surgeon, who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT codes 99231-99233) for the inpatient hospital care and the surgical code with modifier 55 for the post-discharge care. **The surgeon should bill the surgery code with modifier 54.**

Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of E&M code. These services are not included in the global surgical reimbursement.

The physician who performs the emergency room service must bill for the surgical procedure without using modifier 54.

3. Preoperative and postoperative critical care services provided during a global period for a seriously injured or burned client are not considered related to a surgical procedure and may be paid separately under the following circumstances:

Preoperative and postoperative critical care may be paid in addition to a global fee if all of the following apply:

- The client is critically ill and requires the constant attendance of the physician;
- The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and
- Such clients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

Modifiers 24 or 25 must be used to indicate these critical care services (reason for the E&M service must be unrelated to the procedure).

4. Separate reimbursement is allowed for:

- The initial evaluation to determine need for surgery.
- The preoperative visits prior to one day before the surgery.
- Postoperative visits for problems *unrelated* to the surgery.
- Postoperative visit for services that are not included in the normal course of treatment for the surgery.
- Services of other physicians, except when services included in a global package are furnished by more than one physician. (See modifiers 54 and 55)

For endoscopic procedures and minor surgery for which global surgical payment policy has not been generally used, payments are not allowed for a visit on the same day of the surgical or endoscopic procedure unless a documented, separately identifiable service is provided.

Multiple Surgery

When multiple surgeries are performed on the same client, at the same operative session, total payment equals the sum of 100% of the global fee for the highest value procedure.

Reimbursement for the second through the fifth surgical procedure s is 50% of the global fee.

To expedite payment of your claims, bill all the surgeries for the same operative session on the same claim.

When multiple dermatological procedures are performed, the first procedure is paid at 100%, and at 50% for each additional procedure.

If a partial payment is made on a claim with multiple surgeries, you must rebill MAA using a blue Adjustment Request form (DSHS 525-109).

Endoscopy Procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc., are paid at the maximum allowable amount minus the base endoscopy procedure's allowed amount.
- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules apply.
- When surgical procedure s are performed in the same operative session, the multiple surgery rules apply.
- When payment for other codes within an endoscopy group is less than the endoscopy base code, no payment is made.
- MAA does not reimburse for an E&M visit on the same day as the diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier 25 is used (reason for the E&M service must be unrelated to the procedure).

Other Surgical Policies

- Use modifiers 80, 81 and/or 82 to indicate surgery assist procedures. An assist at major surgery by a physician is paid at 20% of the listed value for the surgical procedure. The multiple surgery rules apply for surgery assists.
- MAA covers CPT code 61862, Cranial neurostimulator, only when it is determined to be medically necessary. MAA has determined that only the following two diagnosis codes would be considered medically necessary for CPT code 61862: 333.1 or 332.0.
- **All claims for sterilization and hysterectomy procedures must be accompanied by a completed consent form (see Section H).**
- MAA will reimburse for the use of an operating microscope, CPT code 69990, only when billed with one of the following CPT codes: 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, or 64831-64907.
- The following surgeries are allowed only with diagnoses V10.3, 140.0-239.9, 757.6, 759.4, 906.5-906.9, or 940.0-949.5.

CPT Code(s)	Description
11960	Insertion of tissue expander(s)
11970	Replace tissue expander
11971	Remove tissue expander(s)
19160	Removal of breast tissue
19162	Remove breast tissue, nodes
19180	Removal of breast
19182	Removal of breast
19316	Suspension of breast
19340	Immediate breast prosthesis
19342	Delayed breast prosthesis
19350	Breast reconstruction
19357	Breast reconstruction
19361	Breast reconstruction
19364	Breast reconstruction
19366	Breast reconstruction
19367	Breast reconstruction
19368	Breast reconstruction
19369	Breast reconstruction
19370	Surgery of breast capsule
19371	Removal of breast capsule
19380	Revise breast reconstruction

- Salpingostomy, CPT codes 58770 and 58673, are payable only for a tubal pregnancy (diagnosis code 633.1).
- Modifier 53 must be used when billing incomplete colonoscopies (CPT code 45378). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 only. It is “information only” for all other surgical procedures.

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Epiphyseal

Surgical procedures for epiphyseal (CPT codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.

Closure of Enterostomy

Mobilization of splenic flexure (CPT code 44139) is not reimbursed when billed with enterostomy codes (CPT codes 44625 and 44626). CPT code 44139 must be used only in conjunction with partial colectomy (CPT codes 44140 through 44147).

Angioscopy

MAA reimburses for one unit of angioscopy (CPT code 35400), per session.

Apheresis (CPT code 36520)

Therapeutic apheresis (CPT code 36520) includes payment for all medical management services provided to the patient on the date of service. MAA reimburses for only one unit of CPT code 36520 for the same physician on the same date for the same patient.

Separate payment is not allowed on the same date that therapeutic apheresis services are provided, unless they are billed with a modifier 25 (reason for the E&M service must be unrelated to the procedure) for the following:

- Established patient office and other outpatient visits (CPT codes 99211-99215);
- Subsequent hospital care (CPT codes 99231-99233); and
- Follow-up inpatient consultations (CPT codes 99261-99263).

Do not bill apheresis management when billing for critical care (99291 and 99292) time.

Urology

Circumcisions (other than newborn) (CPT code 54152 and 54161) Circumcisions for clients other than newborns are only allowed for one of the following diagnoses: 605-Phimosis; 607.1 – Balanoposthitis; or 607.81 – Balanitis Xerotica.

Urological procedures with sterilizations in the procedure code description – These procedures may stop in MAA's payment system as a result of MAA's effort to remain in compliance with federal sterilization consent form requirements. If the surgery is not being done for the purpose of sterilization or the sterilizing portion of the procedure is not being performed, a sterilization consent form is not required.

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Physician-Related Services

However, you **must** note one of the following in the *Comments* section of your claim:

- ✓ No sterilization done;
- ✓ No vasectomy or tubal done;
- ✓ Not sterilized; or
- ✓ Not done primarily for the purpose of sterilization.

Bilateral Procedures

- If a procedure **is not** identified by its terminology as a bilateral procedure (or unilateral or bilateral), report the procedure with modifier 50. Bill as a single line item.
- If a procedure **is** identified by the terminology as bilateral (or unilateral or bilateral), as in CPT codes 27395 and 52290, do not report the procedure with modifier 50.
- Use Modifiers LT and RT to indicate left and right for unilateral procedures.

Pre-/Intra-/Postoperative Payment Splits

Pre-, intra-, and postoperative payment splits are made when modifiers 54, 55, and 56 are used.

MAA has adopted Medicare's payment splits where appropriate, as listed below. If Medicare has not assigned a payment split to a procedure, MAA uses a payment split of 10% 80% 10%.

<u>Code Range</u>	<u>Operative System</u>	<u>Pre-</u>	<u>Intra-</u>	<u>Postoperative</u>
10000 – 19499	Integumentary	10%	71%	19%
20000 – 29909	Musculoskeletal	10%	69%	21%
30000 – 32999	Respiratory	10%	76%	14%
33010 – 37788	Cardiovascular	09%	84%	07%
37790 – 37799	Cardiovascular	08%	83%	09%
38100 – 38115	Hemic/Lymphatic	11%	73%	16%
38120 – 38300	Hemic/Lymphatic	09%	84%	07%
38305 - 38999	Hemic/Lymphatic	11%	73%	16%
39000 – 39599	Mediastinum/Diaphragm	09%	84%	07%
40490 – 43641	Digestive	09%	81%	10%
43651 - 43652	Digestive	11%	76%	13%
43653 – 49999	Digestive	09%	81%	10%
50010 – 53899	Urinary	08%	83%	09%
54000 – 55980	Male Genital	10%	80%	10%
56300 – 56399	Laparoscopy/Hysteroscopy	09%	81%	10%
56405 – 58999	Female Genital	12%	74%	14%
59000 – 59899	Maternity	17%	60%	23%
60000 – 60605	Endocrine	09%	82%	09%
60650 – 60699	Endocrine	09%	84%	07%
61000 – 64999	Nervous System	11%	76%	13%
65091 – 68899	Eye/Ocular	10%	70%	20%

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Physician-Related Services

69000 – 69979	Auditory	07%	79%	14%
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Anesthesia [Refer to WAC 388-531-0300]

Coding and payment policies

General Anesthesia

- MAA requires providers to use Anesthesia CPT codes 00100 through 01999 to bill for anesthesia services paid with base and time units. Providers **must not** use the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.
- When using CPT code 01922 for non-invasive imaging or radiation therapy:
 - ✓ The client must be 17 years of age or younger; **or**
 - ✓ A statement of the client-specific reasons why the procedure cannot be performed without anesthesia services must be kept in the client's medical record.
- MAA reimburses providers for covered anesthesia service performed by one of the following:
 - ✓ Anesthesiologist;
 - ✓ Certified registered nurse anesthetist (CRNA); or
 - ✓ Other providers who have a special agreement with MAA to provide anesthesia services.
- For each client, the anesthesia provider must:
 - ✓ Perform a pre-anesthetic examination and evaluation;
 - ✓ Prescribe the anesthesia plan;
 - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
 - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform, are performed by a qualified individual as defined in program operating instructions;
 - ✓ Monitor the course of anesthesia administration at frequent intervals;
 - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
 - ✓ Provide indicated post anesthesia care.
- In addition, the anesthesiologist may direct no more than four anesthesia services concurrently. The physician may not perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by Medicare instructions.
- The anesthesia provider must document in the client's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.

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- Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continuous monitoring of the patient within the blocks of time. Examples of this include, but are not limited to, time a patient spends in an anesthesia induction room; or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesiologist, surgeon or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under postoperative supervision).
- Do not bill CPT codes 01953 or 01996 with an anesthesia modifier. MAA has assigned flat fees for these codes. Do not bill time in the units field for CPT codes 01953 or 01996.
- In addition to the anesthesia CPT codes, MAA accepts two anesthesia codes published in the American Society of Anesthesiology (ASA) Relative Value Guide (RVG). Effective for dates of service on and after January 1, 2002, the ASA RVG 2001 codes 01961 and 01962 for nerve block injections have been deleted and replaced with the ASA RVG 2002 codes in the following table:

ASA Code	Description
02100	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
02101	Anesthesia for diagnostic or therapeutic nerve blocks and injections—patient in the prone position (when block or injection is performed by a different provider)

- Use these ASA codes only when a provider, other than the one performing the block or the injection, administers anesthesia. MAA does not adopt any other ASA RVG codes that are not included in the CPT book. Bill all other anesthesia codes according to the descriptions published in the CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, MAA follows CPT code descriptions. MAA does not reimburse for anesthesia services when billed with the CPT surgery, radiology and medicine codes. **Continue to use the appropriate anesthesia modifier with Anesthesia CPT and ASA codes.**

Exception: Continue to bill CPT Pain Management/Other Services codes that are not paid with base and time units. These services are reimbursed as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

Physician-Related Services

- Effective with dates of service on and after January 1, 2002, state-unique anesthesia codes 5911M – 5915M are discontinued and replaced with the following CPT codes:

Discontinued State-Unique Code	Procedure	Replacement CPT Procedure Code	Anesthesia CPT codes must be used when these CPT surgical procedure codes are billed:
5911M	Vasectomies	00869	55250 and 55450
5912M	Tubals	00851	58600, 58605, 58611, 58615, 58670 and 58671
5913M	Hysterectomies	01962, 01963, 00846, or 00944	51925, 58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550 and 59135
5914M	Hysterectomies	01962, 01963, 00846, or 00944	58200, 58210, 58240, 58285 and 59525
5915M	Abortions	01964	59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856 and 59857

- When billing anesthesia CPT code 01964 indicate in field 19 of the HCFA-1500 claim form or in the *Comments* field for direct entry, magnetic tape or EMC “voluntary or induced abortion.”
- Do not bill CPT codes 00800-00884, 00920-00955 for abortions, hysterectomies, or sterilization procedures. Use the appropriate code from the table above.
- When multiple surgical procedures are performed during the same period of anesthesia, the surgical procedure with the greatest base value should be billed, along with the total time in whole minutes.
- If anesthesia time exceeds 999 minutes, leave the unit field blank. Enter the time in the *Remarks* field or enter beginning and ending time or total minutes on the HCFA-1500 claim form.
- When more than one anesthesia provider is present, MAA pays the supervisory anesthesiologist and the certified registered nurse (CRNA) each 50% of the allowed amount. MAA limits reimbursement in this circumstance to 100% of the total allowed reimbursement for the service.
- The anesthesia payment system is based on a per minute reporting assumption. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

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- Providers must report the number of actual anesthesia minutes (calculates to the next whole minute) in field 24G of the HCFA-1500 claim form. MAA calculates the base units.

Regional Anesthesia

- Bill MAA the appropriate CPT code (e.g., epidural-CPT code 62319) with no time units and no anesthesia modifier. MAA determines payment by using only RBRVS, not anesthesia base and time units.
- Local nerve block CPT code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot and vagina) is included in the package for the surgical procedure and is not reimbursed separately.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.
- MAA follows the Centers for Medicare and Medicaid Services' (CMS's) policy to not reimburse surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare's payment policy, **separate reimbursement** for local, regional, or digital block or general anesthesia administered by the surgeon **is not allowed**. These services are considered included in the RBRVS payments for the procedure.
- When billing for anesthesia services using CPT anesthesia code 01999, submit documentation (operative report) indicating what surgical procedure was performed that require the anesthesia. A MAA Medical Consultant will review documentation for determination of payment.

Anesthesia for Maternity [Refer to WAC 388-531-0300(9)]

- MAA reimburses a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or Cesarean section delivery.
- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).
- In order to be reimbursed, bill the applicable CPT anesthesia code with modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.
- CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969 in conjunction with the base of 6 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code. For example, if an epidural anesthetic is given to a client in labor for three hours while a vaginal delivery is still planned, the provider will report 01967 with a total time of 180 minutes. If the provider decides a cesarean section is then necessary, and the cesarean portion of the procedure takes an additional 30 minutes, the provider will report CPT code 01968 with a total time of 30 minutes on another line of the claim form. The provider will be reimbursed for a grand total of 9 base units and 210 minutes.
- The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT codes 01962, 01963, 01964 and 01969.
- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during one operative session. If the sterilization and delivery are performed in different operative sessions, the time is calculated separately.

Anesthesia Payment Calculation for Services Paid with Base and Time Units

- The conversion factor is \$15.70.
- Anesthesia time is paid using **one minute per unit**.
- The total anesthesia reimbursement rate is calculated by adding the base value for anesthesia listed in this fee schedule with the actual time. Bill time in **total minutes** to the next whole minute, not hours and minutes or multiple-minute units. Do not bill base. The formula for calculating anesthesia payment using total minutes is described later in this section.

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The following table illustrates how to calculate the anesthesia payment:

Payment Calculation
A. Multiply base units by 15 .
B. Add total minutes to value from step A.
C. Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D. Multiply total from Step B by the rate per minute in Step C.

Anesthesia conversion factor is based on 15-minute time units.

Anesthesia for Dental

General anesthesia is allowed when provided by an anesthesiologist for a Certified Registered Nurse Anesthetist (CRNA) for dental admissions. Providers must use CPT anesthesia code 00170 with the appropriate anesthesia modifier to bill for dental anesthesia.

Note: Bill MAA directly for dental anesthesia for all clients, including those enrolled in managed care.

Pain Management Services

- Pain Management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are *not* paid with anesthesia base and time units. **Do not use anesthesia modifiers when billing for services payable only under RBRVS.** If an anesthesia modifier is used with a code that is payable only under RBRVS, MAA will deny the service.
- Two postoperative procedures are allowed for pain management. Only one (1) unit may be billed per procedure. Do NOT bill time.

See next page for Pain Management Procedure Codes

Pain Management Services (cont.)

**Due to copyright restrictions, MAA publishes only official brief CPT descriptions
To view the full CPT description, please refer to your current CPT manual.**

The listings shown below are not guaranteed to be all-inclusive, and are provided for convenience purposes only. Do not rely solely on the descriptions given in the appendices for complete coding information. Please refer to a current CPT book for complete coding information.

The codes listed below with an asterisk (*) are limited to two (2) during the postoperative period while the client is admitted to the hospital. Do not bill modifier 59 with any of these procedure codes.

CPT Code	Description	CPT Code	Description
11981 *	Insert drug implant device	63688 *	Revise/remove neuroreceiver
11982 *	Remove drug implant device	64400 *	Injection for nerve block
11983 *	Remove/insert drug implant	64402 *	Injection for nerve block
20526 *	Ther injection, carpal tunnel	64405 *	Injection for nerve block
20550	Inject tendon/ligament/cyst	64408 *	Injection for nerve block
20551	Inject tendon origin/insert	64410 *	Injection for nerve block
20552	Inject trigger point, 1 or 2	64412 *	Injection for nerve block
20553	Inject trigger points, >3	64413 *	Injection for nerve block
20600	Drain/inject, joint/bursa	64415 *	Injection for nerve block
20605	Drain/inject, joint/bursa	64417 *	Injection for nerve block
20610	Drain/inject, joint/bursa	64418 *	Injection for nerve block
27096	Inject sacroiliac joint	64420 *	Injection for nerve block
61790 *	Treat trigeminal nerve	64421 *	Injection for nerve block
62270	Spinal fluid tap, diagnostic	64425 *	Injection for nerve block
62272	Drain spinal fluid	64430 *	Injection for nerve block
62273 *	Treat epidural spine lesion	64435 *	Injection for nerve block
62280 *	Treat spinal cord lesion	64445 *	Injection for nerve block
62281 *	Treat spinal cord lesion	64450 *	Injection for nerve block
62282 *	Treat spinal canal lesion	64470 *	Inj paravertebral c/t
62284	Injection for myelogram	64472 *	Inj paravertebral c/t add-on
62290	Inject for spine disk x-ray	64475 *	Inj paravertebral l/s
62291	Inject for spine disk x-ray	64476 *	Inj paravertebral l/s add-on
62310 *	Inject spine c/t	64479 *	Inj foramen epidural add-on
62311 *	Inject spine l/s (cd)	64480 *	Inj foramen epidural add-on
62318 *	Inject spine w/cath, c/t	64483 *	Inj foramen epidural l/s
62319 *	Inject spine w/cath l/s (cd)	64484 *	Inj forament epidural add-on
62350 *	Implant spinal canal cath	64505 *	Injection for nerve block
62351 *	Implant spinal canal cath	64508 *	Injection for nerve block
62355 *	Remove spinal canal cath	64510 *	Injection for nerve block
62360 *	Insert spine infusion device	64520 *	Injection for nerve block
62361 *	Implant spine infusion pump	64530 *	Injection for nerve block
62362 *	Implant spine infusion pump	64550 *	Apply neurostimulator
62365 *	Remove spine infusion device	64553 *	Implant neuroelectrodes
63650 *	Implant neuroelectrodes	64555 *	Implant neuroelectrodes
63655 *	Implant neuroelectrodes	64560 *	Implant neuroelectrodes
63660 *	Revise/remove neuroelectrode	64561 *	Implant neuroelectrodes
63685 *	Implant neuroreceiver		

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Pain Management Services (cont.)

64565	*	Implant neuroelectrodes
64573	*	Implant neuroelectrodes
64575	*	Implant neuroelectrodes
64577	*	Implant neuroelectrodes
64580	*	Implant neuroelectrodes
64581	*	Implant neuroelectrodes
64585	*	Revised/remove neuroelectrode
64590	*	Implant neuroreceiver
64595	*	Revise/remove neuroreceiver
64600	*	Injection treatment of nerve
64605	*	Injection treatment of nerve
64610	*	Injection treatment of nerve
64612	*	Destroy nerve, face muscle
64613	*	Destroy nerve, spine muscle
64620	*	Injection treatment of nerve
64622	*	Destr paravertbrl nerve l/s
64626	*	Destr paravertbrl nerve c/t
64627	*	Destr paravertbrl nerve add-on
64630	*	Injection treatment of nerve
64640	*	Injection treatment of nerve
64680	*	Injection treatment of nerve
64802	*	Remove sympathetic nerves
64804	*	Remove sympathetic nerves
64809	*	Remove sympathetic nerves
64818	*	Remove sympathetic nerves

Other Services

31500	Insert emergency airway
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36488	Insertion of catheter, vein
36489	Insertion of catheter, vein
36490	Insertion of catheter, vein
36491	Insertion of catheter, vein
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
62263	Lysis epidural adhesions
62287	Percutaneous diskectomy
63600	Remove spinal cord lesion
76000	Fluoroscope examination
76003	Needle localization by x-ray
76005	Fluoroguide for spine inject
93503	Insert/place heart catheter
95970	Analyze neurostim, no prog

These codes will be paid under RVRVS as a procedure, not with base units and time.

Major Trauma Services

Payment enhancements apply to nongovernmental Trauma Services. Physicians and clinical providers on the Trauma teams of governmental hospitals receive enhancements on a per-patient basis. See page F27 for a list of the Designated Trauma Services. Page F28 lists DOH's categories of Physician and Clinical Providers for the Trauma Response Teams.

Payment Limitations for Major Trauma

To receive enhanced payment, the Department of Health (DOH) must identify the facility as a Designated Trauma Services. The facility's staff must maintain a quality improvement program and submit trauma registry data as prescribed by DOH. Verification of trauma service designation and patients' Injury Severity Score (ISS) will be done by DOH.

Enhanced payments are limited to services provided by a member of a Designated Trauma Services Trauma Response Team for Medical Assistance clients who require major trauma services. (See the Physician/Clinical Provider List, page F28.) Enhanced payments are limited to services performed in the hospital.

These enhancements are for fee-for-service MAA clients only. MAA clients covered by managed care plans have trauma payments included in their managed care rates. Providers have contracts with these managed care plans that may or may not include additional payments for various services such as major trauma.

Nondesignated Centers and Providers

Physicians and clinical providers not identified by DOH as Designated Trauma Services will continue to be reimbursed at the standard rates for Medical Assistance clients. A nondesignated clinic that becomes designated during the course of the year must notify the Provider Enrollment Unit, PO Box 45562, Olympia, WA 98504-5562 of the change of status.

Billing

Physicians/Clinics and Other Professionals: Under certain circumstances, two or more modifiers may be necessary to completely describe a service. When that occurs, add modifier 99 to the detail line along with all other applicable modifiers, including 9T. Billing all modifiers with modifier 99 ensures appropriate payment. Claims billed inappropriately must be rebilled on MAA's blue Adjustment Request Form (DSHS 525-109).

Physician-Related Services

In addition to the procedure code, enter the appropriate condition code or modifier as follows:

Type of Claim	Claim Form	Code/Modifier	Where on claim?
Physicians/ Clinical Providers	HCFA-1500	Modifier 9T <i>Enter this for each detail line that applies.</i>	Field 24d

Additional funds are available for treatment related to major trauma at Designated Trauma Services; however, modifier 9T must be entered on the claim form to receive the enhanced payment.

Note: The current Injury Severity Score (ISS) is 9. Enhanced payment is available for ALL cases with an ISS of 9 or above.

For Additional Information:

For information on trauma service designation, trauma registry and/or injury severity scores (ISS), contact:

Chris Williams
Department of Health
Office of Emergency Medical & Trauma Prevention
(360) 705-6735 or 1-800-725-1834.

For information on **reimbursement**, contact:

Tom Johnson
MAA Reimbursement Section
(360) 725-1834

For information on a specific **Medicaid trauma claim**, contact:

MAA's Provider Relations Unit
1-800-562-6188.

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DESIGNATED TRAUMA SERVICES

Nongovernmental Facilities:

Auburn Regional (Auburn)
 Cascade Medical (Leavenworth)
 Central Washington (Wenatchee)
 Darrington (Darrington)
 Deaconess (Spokane)
 Deer Park (Deer Park)
 Emanuel (Portland)
 Good Samaritan (Puyallup)
 Grays Harbor Community (Aberdeen)
 Gritman Memorial (Moscow, Idaho)
 Harrison Memorial (Bremerton)
 Highline Community (Burien)
 Holy Family (Spokane)
 Inter-Island (Friday Harbor)
 Kadlec (Richland)
 Mary Bridge's (Tacoma)
 Mt. Carmel (Colville)
 Northwest (Seattle)
 Our Lady of Lourdes (Pasco)

Overlake (Bellevue)
 Providence (Centralia)
 Providence (Everett – Colby)
 Providence (Toppenish)
 Sacred Heart (Spokane)
 St. Francis (Federal Way)
 St. Johns (Longview)
 St. Joseph (Bellingham)
 St. Joseph (Chewelah)
 St. Joseph (Lewiston)
 St. Mary Med. Ctr. (Walla Walla)
 St. Peter's (Tacoma)
 Southwest Wash. (Vancouver)
 Southside Community (Arlington)
 Tri-State Memorial (Markston)
 Valley (Spokane)
 Walla Walla General (Walla Walla)
 Yakima Valley/Prov Yak Med (Yakima)

Governmental Facilities and their Trauma Service Level:

Level 1:

Harborview (Seattle)
 Oregon Health Sciences (Portland)
 * Designated by Oregon only

Level 2:

None

Level 3:

Island (Anacortes)
 Kennewick General (Kennewick)
 Skagit Valley (Mt. Vernon)
 Valley Med. Ctr. (Renton)
 Whidbey General (Coupeville)

Level 4:

Cascade Valley (Arlington)
 Evergreen Hospital (Kirkland)
 Forks Community (Forks)
 Jefferson General (Pt. Townsend)
 Kittitas Valley (Cle Elum)
 Klickitat Valley (Goldendale)
 Lake Chelan Community (Chelan)
 Lewis Co. Hosp. Dist. #1 (Morton)
 Lincoln (Davenport)
 Mason General (Shelton)

Mid Valley (Omak)

Newport Comm. Hospital (Newport)
 North Valley (Tonasket)
 Ocean Beach (Ilwaco)
 Okanogan-Douglas (Brewster)
 Olympic Mem. Hospital (Pt. Angeles)
 Othello Community (Othello)
 Prosser Memorial (Prosser)
 Pullman Memorial (Pullman)
 Samaritan (Moses Lake)
 Skyline (White Salmon)
 Stevens Memorial (Edmonds)
 Valley General (Monroe)
 Willapa Harbor Hosp. (South Bend)

Level 5:

Columbia Basin (Ephrata)
 Coulee Community (Grand Coulee)
 Dayton General (Dayton)
 East Adams Rural (Ritzville)
 Ferry Co. Memorial (Republic)
 Garfield County (Pomeroy)
 Kittitas Hosp. Dist. #2 (Cle Elum)
 Mark Reed (McCleary)
 Odessa Memorial (Odessa)
 Quincy Valley (Quincy)
 Whitman County (Colfax)

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#Memo 02-32 MAA

(Revised July 2002)

- F28 -

Major Trauma

PHYSICIAN/CLINICAL PROVIDER LIST

Advanced Registered Nurse Practitioner
Anesthesiologist
Certified Registered Nurse Anesthetist
Cardiologist
Critical Care Physician
Emergency Physician
Family/General Practice Physician with
Trauma Training
Gastroenterologist
General Surgeon
Gynecologist
Hand Surgeon
Hematologist
Infectious Disease Specialist
Internal Medicine
Nephrologist
Neurologist

Neurosurgeon
Obstetrician
Ophthalmologist
Oral/Maxillofacial Surgeon
Orthopedic Surgeon
Pathologist
Pediatric Surgeon
Pediatrician
Physiatrist
Physician Assistant
Plastic Surgeon
Pulmonologist
Radiologist
Thoracic Surgeon
Urologist
Vascular Surgeon

**This program has been suspended.
See Memo 02-14 MAA**

Note: Major trauma procedures are not included in major trauma services enhanced payment.

